Leading Through Uncertainty: Unpacking EM's Future with Dr. Gillian Schmitz Transcript

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Episode Introduction and Guest Welcome

Welcome to a special Heartline Echoes episode where we revisit some of the most impactful conversations from Heartline changemaking in healthcare. This rerun isn't just a replay, it's an opportunity to reflect, reconnect, and reignite the ideas that continue to shape the future of healthcare.

Whether you're hearing this for the first time or returning for some fresh insights, let's dive back into this powerful discussion. Enjoy! Welcome to Heartline, Changemaking in Healthcare.

I'm your host, Dr. Andrea Austin, a board-certified emergency physician, physician development coach, and educator. After years on the front lines, I've learned that real change in healthcare starts within.

Each episode invites you to explore the inner work that unlocks clarity and bold leadership, because healing systems through changemaking begins with following our heartlines.

I am thrilled to have with me today my friend and colleague, Dr. Jillian Schmitz, an associate professor at the Uniform Services University and an emergency physician at Brook Army Medical Center in San Antonio, Texas.

She currently serves as the immediate past president and member of the board of directors of the American College of Emergency Physicians. Jillian, it is truly an honor to have you on the podcast today.

Thank you, Andrea. It's an honor to be here today and I'm excited to speak with you and your audience. This is going to be really fun. So I want to actually start with a few things we mentioned in your bio because you and I are civilians and we still are professors with the Uniform Services University and we both work in some capacity for and with the military.

And I think that's a really interesting career path that maybe some of our colleagues don't know. It's almost like you have to be in the know to know about these government jobs that come open.

Civilian Careers in Military Medicine

So maybe that would be a good place to start about how can you be a civilian and work with the military? Sure. That's a great question. So I have never been in the military.

Many people think that I have been because I have worked in a military residency program for many years now, but my husband is active duty air force and we met in med school.

So I first heard about this and knowing that I wanted to live in the same place as my husband. And it became difficult to match our careers because he was constantly moving with the military.

Um, and I inquired about what positions might be available in an academic military environment. And was pleased to see that we have actually a number of civilians who work in military hospitals, just like we have a number of civilians working at the VA.

It is an amazing patient population to care for. It is a great place to teach and to train. And I really do believe in the mission of military medicine and really learning to how to protect and fight for those who serve our country.

So I would encourage people to ask around. There are a number of different sites that post military jobs or reach out to one of us. We can probably make some introductions.

And I'll give a shout out to the uniform services university who's hiring a number of positions. If anyone's interested in moving to Bethesda, Maryland.

Yeah. I think it's such a really important career path for people to understand that you can be a civilian and work for the VA or for the military. And if we have any medical students listening, I didn't even know about the uniform services university when I was applying to medical school.

And you and I both have worked at this point with a number of medical students. And I consistently say that the students that I work with from the uniform services university will number one are the most professional group of students that I ever interface with.

And I would hold them up academically against any medical school in the country. And so I just think the overall quality of medical school graduate that we produce from the Uniformed Services University is something to be very proud of.

I could not agree more. I think the fact that it is tri-service and army, air force, Navy, but there's a sense that we're all on the same team and we have a fighting for a common goal and mission that these are medical students who are not your typical cutthroat trying to climb the ladder is all about teamwork.

And really that's what emergency medicine is. It's learning how to play a team sport and work well with others and could not agree with you more about just the professionalism and high academic standards.

It's been a great place to both teach and do research and really work with our medical students across the country. It was by no means an attempt on my part to talk so much about the Uniform Services University, but I do think it's a hidden gem in academic medicine.

Career Setback and Leadership Pivot

And if people are looking maybe to do something a little bit differently, certainly I know we have a number of listeners in the DC area. Well, I want to pivot to talking a little bit about your overall career trajectory.

And I had the benefit of being friends with you. And I've also listened to your talk that was at an FM a number of years ago. And you tell a story about what you thought your career was going to be and then kind of The challenge that came up and then things went in a new direction that really pivoted you into working more with ASAP and having a very well the biggest role that you can have as an emergency physician as the president of ASAP.

I think what I love about this podcast is we don't just focus on the highlights because every guest we've had on here has had something similar that there was a setback.

There was something that happened personally or with their family or with their career that made them change directions. So what was that for you? Thank you for asking that because I think we don't talk enough about our failures.

Everybody has failures, but mine was a career setback that really made me rethink about who I was and what I wanted to do. My background as a resident, I was involved with EMRA, the Emergency Medicine Residence Association.

And my position on that was to work with the program directors and to work with all the educators to really help improve resident education. And I thought, gosh, when I grow up, I want to be a program director someday.

I want that more than anything. And I go head first and did everything I could to really prepare myself for that role. And I was chief resident and I did all the right things and was assistant program director and then associate program director.

And I was presenting at these education meetings and thought I had checked all the boxes. And when it came time

for my interview to assume that program director position, my chair chose someone else.

And it was pretty disappointing. It really surprised me that I thought I was really ready and that timing was the right time for me. But people have other plans and life sometimes takes a change in direction.

And I had the option of staying and just waiting, you know, however long, maybe 10 more years until it was my turn, but that just didn't seem satisfying.

And suddenly I had to reevaluate. What did I really want to do? And what was that path? And for a while I really had a hard time with it. I wasn't sleeping as well.

I wasn't enjoying what I was doing anymore. I sort of lost that momentum. And I remember sitting down on the couch with my husband and having a glass of wine and trying to figure out my next step.

And he had suggested that I had been so involved in ASAP and advocacy that maybe I could pivot and do something different and do something crazy, like run for the board of directors.

And that's unusual because at ASAP, typically that's the end of people's career, at least it had been historically, of people who had been out in the workforce for 20, 30 years and were looking to really retire and have more of a role in the national leadership position.

And part of me had that imposter syndrome where, gosh, I didn't get a job at a local level that I honestly felt I was pretty qualified for. How can I possibly put my name out there and run for a national leadership position?

That seemed a little daunting. But my husband, who is a huge advocate for women in medicine and women in leadership was like, you know, you lose a hundred percent of those risks that you don't take.

Just what's the worst thing that could happen, right? You go and you don't win. Who cares? So I put my name in the hat and I had a wonderful campaign team.

That's mainly you and got to work with some great people to help me prepare. And I did my campaigning and my debating and gave my speech and I was elected on the first time, which is pretty unusual historically for someone to get elected on their first run.

But it put me in a position where I got involved on a much deeper level on health policy and advocacy, and then eventually went on to be president of the college.

And it ended up being the most, you know, reporting professionally challenging opportunities I've ever had and opened up a number of doors. And I think it filled that void and it gave me that sense of purpose and direction that even though I didn't get that job that I thought I wanted.

there was a much better direction in a different way. I just wasn't able to see it in the heat of the moment. But I think oftentimes when life closes the door, it opens a window and you have to find kind of what is that other opportunity and realize that sometimes not getting what you want or not getting that job is really the best thing that can happen to you because it forces you to look at what else and what other opportunities that we may not have considered previously.

And for me, that was certainly a pivotal moment and a change in my career that I think really put me on a new trajectory. I just love that story because now I'm going to put you on the spot.

How many members are there in ASAP? About 40,000. So you have very directly impacted the lives and careers of each year, 40,000 emergency physicians.

Emergency Medicine Workforce Outlook

And if you had become a program director, and who knows, maybe you will someday, while it's an incredibly important and impactful role, your reach was exponential by moving into ASAP.

Absolutely. I think it really opened up a bunch of new opportunities and networking and realization that I could do something on a level that would impact many more people.

And I really want to encourage other women that are having those setbacks or those moments where things aren't going the direction that they thought, or they didn't get that promotion to not let that stop you to really be resilient and face this as this may be an opportunity and a launching pad for.

something totally different. And I think we need to start talking about that a lot more about women in medicine and how we support each other through those difficult times to help find what's coming next.

Yeah, what I see a lot of and I'm interested on your reflections on this is so you and I work with military women a lot. So maybe you make the decision that you're going to stay for 20 years because you want that retirement.

Or maybe you work for X organization that also offers a very lucrative. You're very excited about the retirement package. And there might be a period in your career in which you have a chair or somebody else that you just don't vibe with.

And maybe you've tried everything in your toolbox to really make that relationship work. And, you know, one option is to quit or leave, which you possibly can do.

Sometimes our military folks actually can't, they're in a contract maybe for three or four or five years that they can't leave. So what I see a lot of the time is that happens and people are so frustrated and so dejected, burned out, whatever their situation is, where another option would be, OK, well, I can't quit or leave this job, or I don't think that's the right thing for me to do financially for my family, my retirement.

But could you stay and do what you need to do there and then start to put energy into something else? Absolutely. I think we really have to look at all your different options, right?

And sometimes that's leaving, but oftentimes it's just reinventing yourself and potentially realigning your skill set with what is most needed in your department.

And that may be something you had never considered before, but something that your boss may see in you of a different route, a different skill set that they really need that will open up again, new avenues and new exposures.

I had a number of friends who were interested in the academic education pathway and then pivoted to operations and are now running hospitals and running departments.

And it's really neat to see that progression of opportunities where they had never seen that in themselves, but were willing to give something else a try.

Or maybe that simulation, maybe it is ultrasound, maybe it is working in critical care and working with other departments. The neat thing I think about emergency medicine is that we're constantly evolving and there's so many different past and career opportunities within our specialty that it allows us all to grow.

Well, I think that's a great bridge to what maybe I didn't send you in a pre-question, but I think we can talk about is the EM workforce report. And I'm going to tell you my take on it.

And then I'm interested in where you agree and even more interested in where you may disagree and want to reframe it. So I think number one, the EM workforce report, some of the data that went into it, the conditions or considerations have just changed.

So we are seeing more physicians retire sooner, which is going to change the overall number of physicians that we

need. The other thing I'm really interested in is the demand side that what I'm seeing, you know, coming out of the pandemic is primary care has changed and they are not seeing as many patients.

They're seeing more patients on telemedicine and as much as I love telemedicine, not everything can happen on telemedicine. And various patients have different comfort levels with telemedicine.

So for all those reasons, I think the demand side is just going up and up and up. We're going to see more attrition in the field. And then the last thing is I really feel like we're on the precipice of a major change in the way medicine is delivered.

And I think emergency medicine physicians are perhaps the best positioned to be able to meet that changing need. Similar to how general surgeons. taking trauma care or trauma call pivoted to being acute care specialist.

I really see emergency physicians as being the specialists and I think ASAP uses this line acute unscheduled care and thinking about how do we extend the porch, the front door of emergency medicine and how do we go out into the community, whether that's mobile assets that can follow up with patients, do some point of care labs.

I've been hearing about these things happening. I could go on and on, but I want to pause and get your take because you've been at many meetings about this and with many of the thought leaders and leaders across the medical fields on what's going to happen.

Well, first of all, what a great question. And I love the sense of optimism and hope and change, which is exactly what I feel. You know, workforce reports are challenging.

ASAP has tended to, every 10 years or so, put out a workforce report knowing that we are one of the newest specialties. And so things are really evolving pretty quickly with what is a projected surplus?

What is a projected demand? But all of those workforce studies are based on a number of variables that are very apt to change and can be rapidly incorrect.

And that was the whole point of the workforce was to project several years in advance what might happen so that we could change things so those predictions would never come true.

And I think we're already starting to see the effect of that. As you mentioned, the workforce study was done with data pre-COVID. So one major disruptor is the pandemic.

And certainly we're seeing a much higher attrition rate than what was earlier predicted based on those anticipated changes. And so we're seeing not only because of the pandemic, but the changes in the job market, changes in what people and hours people are willing to do, having the ability to work from home.

ASAP Advocacy Wins and Documentation Reform

It really has changed people's perspective. So even if you change that attrition rate by just two percentage points, it drastically changes that prediction of what the supply side would be.

And the demand side, I think, is what is really the most exciting part, as you talked about. And it would be silly to assume that emergency medicine is going to look like it does today, 20 years from now.

Every other specialty has adapted and evolved and changed. If you look at anesthesia, They had a workforce challenge a number of years ago where they thought they were going to have too many anesthesiologists.

And they evolved beyond just being in the operating room and doing airways to doing pain management, to doing much more outpatient, to working in these kind of freestanding hospitals to deliver care.

And now it's the exact opposite. You can't hire anesthesiologists if you try, they're such high demand. So what is

emergency medicine going to look like in the future?

I completely agree with you. We have this almost unbelievable demand for acute unscheduled care that we are uniquely qualified to be able to provide. So whether it is looking at freestanding emergency departments, whether it's urgent cares, whether it's hybrid models, Some component of telemedicine, really emergency medicine is adapting and we are increasingly going into new fields that use our skills, like critical care, like being a hospitalist, working into other ways that we can deliver that healthcare.

We're seeing a huge growth in the number of emergency physicians who are really leading hospitals. So CMOs of health systems are emergency physicians.

We see emergency physicians going into politics. Who else better understands really that unique approach to the inpatient and outpatient world where everything kind of comes to a head?

That's us, right? And we're problem solvers. We are people who have to be political. We have to navigate so many different personalities and bring everyone together to best serve the needs of the patient.

So I think there's going to be increasingly a huge demand for our skill set and our practice environment. While we're always going to have sort of the bedrock of clinical medicine, I think there's going to be many more opportunities in the future to what we can do and what our practice is going to look like.

I'm excited. I think I went through a phase, maybe not unlike a lot of people, probably the first six months of COVID that, you know, all is lost. And it did feel very, very dark.

Now I want to get into a little bit of what some successes have been during your time as ASAP president and I want to challenge listeners. It's very easy right now to be incredibly negative.

And I don't believe in false positivity either. But, you know, I think it was yesterday or day before I got an email from ASAP and I noticed that you no longer need an ex waiver to prescribe buprenorph.

I can't even say it. Please say the full word for me. But our listeners know what I mean. And to me, that's it. That's something that ASEP has been working on for years and is a tangible thing that makes working in the emergency department better.

So if you had to list the top three things that you're really proud of that you personally were involved in or you know ASEP did in the last couple of years, what would it be?

Oh my goodness, that's a loaded question. One I think was really working well with all the other EM organizations to look at accreditation standards for residency.

You know, one of the things I'm most proud of is really helping to build residency and to be involved with resident medical student education. And we really want to ensure that we are not cheapening that by having the bar so low that emergency medicine residents, it pop up left and right like McDonald's on every street corner.

And I think that was a concern that came out of the workforce is that are we opening too many residencies? So we created a partnership and have made some really evidence-based recommendations where there is numbers on looking at procedures and really the staffing ratios and who is working in your emergency department and number of critical care and research and really all different things of how we can ensure that we are best preparing our students for a really bright future and ensuring that they're getting the highest amount of training that is not being diluted by people who have other intentions of growing the workforce.

So that would be number one. Number two, I would say is passage of the Lorna Breen Act. So Lorna Breen was an emergency physician who tragically took her own life.

She had no known psychiatric issues before the pandemic. And this really highlighted what stress we are under as

emergency physicians and recognizing that it's okay to talk about it.

And we need more resources and we need more support for our emergency physicians and healthcare providers in destigmatizing mental health. of getting rid of questions that are completely unnecessary and inappropriate.

State licensure applications about previous mental health and encouraging people to really use the resources that are there and increasing the amount of funding, particularly for mental health and emergency psychiatric care to make sure that we are best treating those patients, that they're not waiting for decades in our emergency departments for beds and improving the resources and really commitment to emergency physicians.

So that was a big one. And the third one, I will say that we had a big role in ASAP was looking at these proposed documentation changes that just got rolled out.

But a lot of it used to drive me crazy that we had document, you know, 10 review of systems when somebody was there with a splinter in their finger and you had to document a social history, you know, about their smoking use when they're there for, you know, as a corneal abrasion.

It just didn't make any sense. And so a lot of the suggestions we made helped improve the documentation and it's going to be much more streamlined on our medical decision-making and what's really relevant to their presentation and gets rid of some of the unnecessary paperwork and check boxes that I think we're all causing a stress with our EMRs.

And then I'll throw in a fourth one that's a little bit more difficult than we can get into it a little bit, but. Certainly the surprise billing issue and working at, at fair reimbursement for physicians.

And this is something we've been working on for literally years, but to get a law passed on this and to have something that was reasonable for emergency physicians and still fighting the implementation of it.

But that has been, I think, a huge effort of emergency medicine and ASAP in particular, and helping to advocate for our members. So I want to come back to the surprise billing, but I'm actually really happy that you brought up the documentation thing.

And I think this is a perfect topic for us to spend a few minutes on and look at what happens with negativity and kind of this, the sky is falling mindset, which I have been guilty of having many times in my career.

So when I read the information coming out about the changes in documentation, I had the same response that you just outlined. Like, oh my gosh, I don't have to worry about five or six little nitpicky things in my HPI or this crazy review of systems.

And it looks like this documentation change is actually focusing on what we do as emergency medicine physicians, which I always tell my residents, the medical decision-making is your thought process.

That is what you are getting paid to do. That's why you have toiled for all these years, because that's what you do that nobody else can do is think through what's best for this patient with their particular issues and everything that goes into that.

So change is hard. What I'm hearing on the ground is just huge apprehension with this change that, you know, we're worried about our reimbursement going down even for a couple of months, which could be sizable, you know, potentially.

And so people have a lot of fear going into this change. How can you that the doctor that's listening to this driving into their shift right now saying I'm just really worried that my reimbursement is going to be cut because of this billing change in the next couple of months and maybe I'll figure it out but you know dang it I'm really irritated about this right now.

So the first thing is that we have to all get smart. We have to understand what the rules are so that you are maximizing your potential coding of what you're documenting and how you're stating it.

ASAP has a number of resources and webinars. There's a great reimbursement conference that's going on right now to really help prepare people of what you need to say, what you need to ask and really what we're already doing in our history and physical, but how you document.

So things like the addressing patient social determinants of health, asking, you know, families are getting records from an outside hospital, all those things that we're routinely doing, but not always documenting, as well as just your differential to explain if you considered pulmonary embolism, but you did not do a test, why that was still part of your cognitive process and why you did not order tests.

And I think in some sense, this actually may improve reimbursement because oftentimes the insurance companies like to play all these games, right? They down code a chart for shortness of breath.

If the diagnosis ends up just being bronchitis, for example, they'll say, well, that person didn't need to be in the emergency department.

Surprise Billing, Reimbursement, and Closing Remarks

This was just a very low level chart. But the reality is, you know, patients don't have a diagnosis when they come to the ED. It's the whole kind of cat and mouse game of which came first, but when they come in with a set of undefined symptoms.

And oftentimes we have to consider other diagnoses when we roll things in or roll things out to come to that diagnosis. And so where before an insurance company could down code your chart and say, you know, after the fact that we now know their diagnosis of bronchitis, they didn't need to be there.

Now part of the kind of point system with your documentation is going to be based on what is your differential or why did you not pursue that with advanced imaging and your absence of imaging does not mean that it's down coded.

It further justifies your thought process of what you considered. And that's really what we should be doing as emergency physicians of having differentials and thinking through why we're doing what we're doing.

I think there is some concern that the amount of documentation will potentially down code some 99285s to 99284s. And it's going to be important that we keep up with the requirements to make sure that we are documenting appropriately.

But I think this should streamline the process once we get used to it. And like anything else, it's changes hard and there's kind of that resistance to learning a new method.

But I think within time, this will become sort of second nature to many of us and we'll hopefully have. better medical legal, medical decision-making documentation to help us, not just because we're getting paid for it, but because it's just better medicine and better documentation of what we were actually thinking and doing at the time we saw the patient.

And I think the line you said about getting reimbursed for our thought process, I think it's so important. And I remember early on in residency having an attending that really liked ordering fewer tests.

And he would tell me, if it takes you five or 10 more minutes, to be in the room, to get additional history, do a more thorough exam and feel confident that you don't need to order the CT, you've actually saved several hours, you know, along with the radiation exposure to the patient.

And so we challenge our listeners that this is actually more rewarding medicine because the truth was you could

add on a CT to add complexity under the old system, where under the new system, it's sounding like just talking through your reasoning a little bit more, you can avoid the CT and get compensated for that extra few minutes you may have had to spend at the bedside.

Exactly. And I think addressing things like before social determinants of health wasn't necessarily a level of complexity. But if you are discussing some of the issues with a patient unable to fill their medications of needing a ride home or language barriers in the emergency department, all that now will be taken into account in your medical decision making and help with the complexity of your chart of things that service we are providing in the emergency department that was not really previously compensated that now will be.

that's exciting. And I truly hope that makes an impact for our underserved emergency departments that are really struggling to make ends meet that they do have to spend more time making sure, you know, a patient has food and shelter and a way to get their medications.

So yeah, hopefully our listeners are getting a little pot of gold at the end of this rainbow that it's not all doom and gloom in emergency medicine. I can't think of a more exciting time to be an emergency physician.

I think this is really whenever we have that dark spot launches us into that next kind of opportunity and you can only go up from there. Right. But I think that's who we are as emergency physicians is that we are resilient.

And we do learn how to make the best of our environment and to be able to adapt quickly to challenging situations with little information and to make the best out of it.

And I think there is increasing recognition that our job is tough and that there needs to be more resources to support those of us who do care for the majority of Americans who don't have access otherwise and really should be proud of what we do and will continue to serve our country with.

All right, folks, so we're going to leave it there with part one of my interview with Dr. Jillian Schmitz. We'll be back with part two next week where we deep dive some really important policy issues that are affecting emergency medicine and really all physicians in general.

And we'll talk about why being involved in organized medicine is an important way to amplify your voice and why we need physician voices right now, especially.

So without further ado, I want to tell you guys some exciting news. So many of you know I'm the chair elect of the American Association of Women Emergency Physicians.

And I am so proud to announce that we are going to be having in-person meeting, an in-person conference. It's called AWEP's Power Up Women in Emergency Medicine Leadership Workshop.

It is in Washington, DC, and it will be April 30th, preceding leadership and advocacy, which will continue on in DC until May 2nd. Our agenda is just amazing.

We are going to have a super wonderful keynote speaker and some really interactive small groups. And I'm just super proud of the conference that we've been able to put together.

And if you were a fan of Feminem, I think you're going to be very pleasantly surprised by many of the people that will be there and speaking. and the vibe we have created.

So if this sounds like fun to you, head over to www.asap.org slash lac slash aweps dash power up. And I will include that in the show notes. I am looking forward to seeing you all in person and we hope you will follow us over there and join us in DC.

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